THE SOCIAL AND REHABILITATION

Record

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Legal Victories for Handicapped ◆ Goal Planning ◆ Industry and Rehabilitation ◆ Service Direction ◆ Work Incentives ◆ Career Opportunities ◆ New Books

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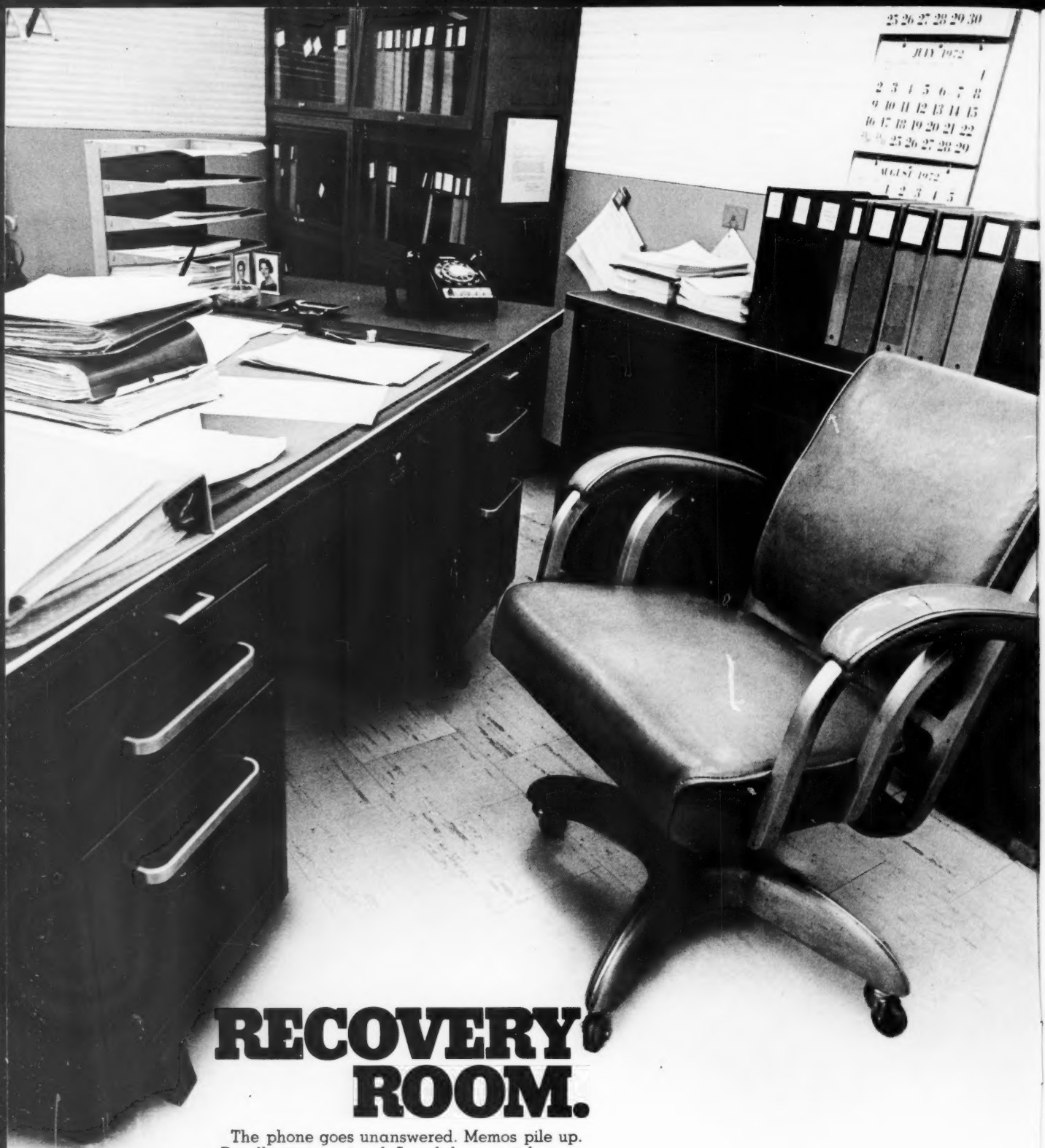

RECOVERY ROOM.

The phone goes unanswered. Memos pile up.
Deadlines are missed. Lunch hours get longer.
Office hours get shorter. The alcoholic employee.
It's hard for him to pull his own weight.

Alcoholism. A major public health problem.

THE SOCIAL AND REHABILITATION
Record

Volume 1, Number 5 May 1974

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U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
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James S. Dwight, Jr.
Administrator, Social and Rehabilitation Service

Robert A. H. Wilson
Assistant Administrator for Public Affairs

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Computer reports on job training success

Computers will soon be informing the California Department of Rehabilitation which of 1,000 schools have been most effective in training handicapped people for work.

The State agency has devised a computerized system of retrieving information from its records of training services purchased by its rehabilitation counselors throughout the State. The system identifies each training school used and supplies information on the time, cost, and results of the services provided.

During the past year the California department paid $11.5 million to private and public schools to train 24,387 of its handicapped clients for work. Alan Nelson, State rehabilitation director, said that the new system will be tested in nine northern counties before it is extended statewide.

Young addicts are helped by Conn. program

Teenage drug abusers in Connecticut receive a combination of both medical and counseling treatment as provided by an innovative program which was instituted by two State agencies. Cooperating agencies are the University-McCook Adolescent Drug Dependency Program (ADDP) and the Connecticut Division of Vocational Rehabilitation (DVR).

When the teenager is first accepted into the program, he undergoes at least 30 days of inpatient treatment in the University-McCook Hospital. During this time the drug abuser is helped through the difficulties of withdrawal, thus breaking his self-destructive habit.

While the addict is still in the hospital, phase two begins. The teenager's individual problems are carefully evaluated by representatives of both ADDP and DVR. A specific guidance-treatment program is evolved to suit his particular needs.

Once he is discharged from the hospital, the youth is placed under the guiding protection of a concerned DVR counselor. The counselor will keep in close contact with his young charge. He will offer advice and direction in the hope that the teenager will stay involved with the various followup aspects of the DVR treatment program.

The long term assistance available to these young patients includes continued public school attendance, training courses, sheltered workshop employment, and further treatment of other medical or psychological problems.

The associated leaders in ADDP and DVR consider their program to be more than just a rehabilitation effort; they see it as really a program in habilitation, that is helping these young people live more normal lives.

Boston program finds jobs for handicapped

Project RETAIN of Brookline, Mass., has placed 613 disabled persons in jobs with small organizations. The SRS-funded agency set up shop a year ago and is sponsored by the Vocational Service of Boston. It is one of three such agencies in the country.

The fact that 50 percent of the workers have been retained after a year seems to indicate employers' satisfaction with the mentally and physically handicapped persons they have hired. The public's lack of knowledge about the program is reportedly the agency's main problem, and efforts are underway to alert hospitals and rehabilitation and social service agencies to the availability of clients for jobs.

Iowa college launches prison education plan

The inmate education program at Iowa State Penitentiary has been taken over by Southeastern Community College. Both institutions are at Fort Madison, Iowa.

The plan was developed through the cooperation of officials at the prison and college, State Department of Public Instruction, and the Vocational Rehabilitation agency.

For several years three college-level courses have been held for inmates in auto mechanics, building trades, and commercial cooking, and there have been other noncredit, vocational courses provided by the prison. Under the new arrangement, inmates may earn college credit in the three areas already established as well as auto body repair, electrical occupations, air conditioning, graphic arts, machine shop, and welding. In addition, there will be general education courses at college level offered at the prison, including communication, mathematics, drafting, blueprint reading, psychology, and sociology.

Inmates may earn associate (2-year) degrees and credit toward baccalaureate degrees.

Elementary and secondary education will continue to be available to inmates through adult basic educa-

tion and general educational development programs.

Vocational education and prison maintenance will now be separate functions.

National project picks rehabilitation agency

Oklahoma's Social and Rehabilitation Services has been selected by the U.S. Department of Agriculture to develop a model system for automating the operation of the State's food stamp program.

The completed system developed by Oklahoma, which was one of 15 States applying for the project, will be made available to other States by June 30.

Rest areas posted for handicapped travelers

Rest areas along the highway system in California are being modified to accommodate the handicapped. The standard symbol signs for the handicapped, measuring 24 x 24 inches, are being installed below the highway rest area signs at those sites with facilities for disabled persons. These include all roadside rests built since 1969 plus some others that have been modified. The modifications include extra wide parking slots, ramps, and specially equipped toilet facilities.

Minnesota Doctor controls spasticity with drug injections

Research and Training Center staff at the University of Minnesota has developed a technique to control spasticity in a muscle while retaining a desirable degree of its function.

Spasticity is one of the main obstacles in the rehabilitation of patients with central nervous system dysfunction. It causes not only unsightly movements but interfers with the patient's activities of daily living.

The technique consists of localizing certain motor points in the spastic muscle and injecting 11cc of 5 percent phenol solution in water into this point. The phenol acts instantaneously, causing contraction to cease and permitting the practitioner to determine immediately whether more injections are needed.

Over 400 such motor point blocks have been performed by Dr. Essam A. Awad on patients with hemiplegia, paraplegia, quadriplegia, cerebral palsy, arachnoiditis, and multiple sclerosis. The procedure is simple; the patient need not take drugs affecting the level of consciousness; skin sensation is not affected, preventing the possibility of decubiti (bed sores); no postoperative limitation is required; and the effects last from 3 to 12 months.

Virginia DVR trains homebound persons in computer technology

Twelve severely disabled clients of the Woodrow Wilson Rehabilitation Center (WWRC) in Fishersville, Virginia, are learning to become computer terminal operators and computer programers. Once training is completed at the center, the clients will work from their homes, a feat made possible through the recent development of remote terminal oriented data processing technology.

Cooperating with WWRC in the venture is IBM. Funding is through State matching funds and an RSA expansion grant to the Virginia Department of Vocational Rehabilitation. While WWRC will provide the training, IBM will identify jobs, assess systems capacities and costs, and analyze jobs and computer systems for modification to the capabilities of disabled workers.

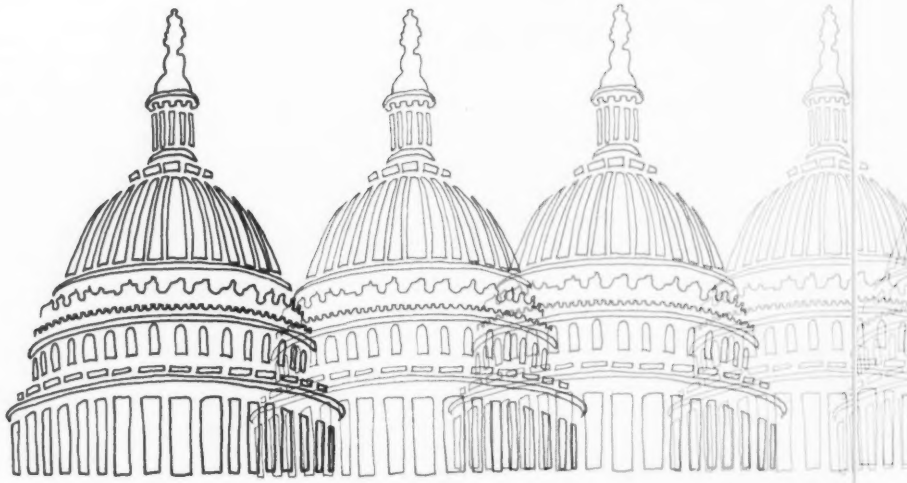
Study predicts job shortage for youth

According to a study conducted by the Connecticut Manpower Executives Association and presented at HEW's Boston regional office, job outlook will continue to be bleak for people under the age of 35 for the next few years. While the study focuses on Connecticut, its implications are considered national in scope. The 155-person team projected the opportunities and characteristics of the poor against the backdrop of broad economic and employment trends.

The study revealed that the economy will face a labor shortage of those in the prime working age brackets and a labor surplus among the young. Additionally, the study pointed out that better jobs will continue to go to the suburban communities rather than to the residents of central cities. The study also comments on areas of health, education, transportation, and discrimination as adversely affecting job opportunities for black and Spanish-speaking youth.

New Directions in Service

FRANK C. CARLUCCI



Taxpayers spend around $126 billion for human services provided by the Federal Government alone; but both taxpayers and intended recipients do not get their money's worth. The root cause of the shortfall: we do not have one human service network; we have hundreds of narrowly-based health, education, welfare, and manpower programs. And they are operating in virtual isolation from one another.

Sixty percent of the people who seek social services are turned away. Of those who actually open an agency's door, only 17 percent are served. But that's only one measure of the system's failure. In addition, 9 of every 10 persons entering a human service agency need not only one service but several.

For instance, a disadvantaged teenage girl who gets pregnant needs at least nine services—prenatal medical care, nutrition guidance, guidance on being a parent, continuation of high school education, obstetric and pediatric care when her baby is born, vocational education, job placement assistance, day care for her child so she can work, and family planning to help her avoid unwanted future pregnancies. Failing even a few, the odds strongly favor her becoming a "regular" on the AFDC rolls. In fact, about 80 percent of our Nation's AFDC population consists of women and children in fatherless homes.

In calculating the odds of a person getting all the services he needs, we come out to a flat *zero*.

Or, turning the human-need equation around: Say that a person needs only one service to become self-sufficient. Say a man needs job training, but doesn't get it. That single agency failure can set off a chain reaction. He has to go on welfare. Or he steals, lands in jail. If he doesn't get vocational training there, he's still headed down the pipe, using public agency resources all the way. He may become a chronic offender, using more police and more court resources. He may become an alcoholic or a drug user, using still more agency resources.

Now he's a one-man epidemic of human service needs. Meanwhile, his family uses public resources like there was no tomorrow—and for them, there isn't. This futile, endless consumption of public resources can happen because an initial human service need was not met. That is today's human resources delivery system—or nonsystem: waste at a colossal rate. And with few exceptions, it is not working.

Similar inefficiencies and inequities plague the other major human resources effort of Government: direct income support programs.

Our welfare system is the major case in point. As President Nixon has often noted, it makes a mockery of our most humanistic instincts, offering disincentives to work, result-

ing in unequal and unfair treatment of human beings solely on a geographical basis. It wallows in administrative chaos.

That's today. Can we do better tomorrow? We can. It will take time, planning, money and, most of all, a common understanding of the problems we are facing and a common determination to find solutions.

The problems have come about largely because of a failure to plan comprehensively. The nonsystem is in pieces because it was legislated piece by piece. Every time a human need was recognized—public housing, food stamps, day care, veterans' pensions or whatever—Congress was implored to pass a law. And it did. This narrow-purpose, categorical aid legislation was added slowly until 1960. Then the dam broke. In 1960, we had around 200 federal aid programs, today more than 1,000!

Their coordination from Washington is not practical. Grassroots coordination has been tried, but even there success has been elusive. Too many federal laws and regulations separate these programs from one another. And in separating programs, you separate the people in charge, while fragmenting the service as well.

A few years ago, the President saw what was happening. He saw local governments hogtied by all these Washington-based programs. He saw the utter impossibility of coordinating them all from separate Washington bureaucracies. From the insight, his new Federalism program sprang. Today, we are well along with this program, but we are not there yet.

New Federalism returns money and decisionmaking where it belongs, to the local and State level. General revenue sharing legislation was a big step in that direction. It will put $30 billion in federal "growth" revenue into the hands of local and State officials in the next 5 years, to use as they see fit, no strings attached.

The next step is to get Congress to consolidate narrow categorical aid programs into block grants. This would allow States to set their own priorities and make their own funding decisions. Although local officials would have the flexibility to meet their community's own unique problems in their own unique way, strong safeguards would insure that major *national* goals would be met.

We also are doing other things to cut the federal ties that bind States, cities, and counties.

HEW's decentralization program is one. It puts more day-to-day decisionmaking authority in regional offices. The day is coming when a local official no longer will have to try to reach some low-level guy buried in the Washington bureaucracy when he wants to be heard about some HEW program affecting his locality.

With decentralization, the "Fed" will be closer to the local scene, better understand local problems,

have the authority to resolve those problems, and have every incentive to be responsive because, unlike the Washington bureaucrat, he will have a regular, ongoing working relationship with the local administrators.

These new Federalism initiatives are steps along the way to a coordinated human resources delivery system. But we still have big problems to solve. We also must begin to reorganize and redirect our direct income support programs—programs such as welfare, social security, government pensions, rent subsidies, Medicaid, and food stamps.

Welfare is our most conspicuous example. We need to make sense out of our so-called welfare system, and we will. We are working now to end the fraud and the administrative chaos. But once that is done, serious structural problems remain, and we have got a task force at HEW working on these right now. One thing they are looking at is how our present crazy-quilt mixture of straight cash and indirect cash programs are producing injustices all across the land.

One study in New York City showed that a man with a wife and two children, earning $7,000 a year on his job, is only $200 a year better off than his neighbor down the block on welfare with the same size family. In other words, that first father has only a $200 a year incentive to work. Welfare, Medicaid, school lunches, food stamps, and other in-kind benefits have put both men on equal income grounds. And if the man on welfare is earning money "under the table," as some do, he's way ahead of his friend down the block who heads out the door every morning with a lunch box under his arm.

That is not a freakish example: 30 percent of all the jobs in New York City pay less than $90 a week, while the fathers of welfare families get benefits equal to $135 a week gross earnings. These inconsistencies are not confined to New York City, and they are not confined to welfare. They run through the whole fabric of government income and income-benefit programs. We are exploring ways to end these inequities and disincentives to work.

One approach involves what Secretary Weinberger calls "revenue sharing for individuals." We simply would put more cash directly into the hands of individuals for use as *they* see fit—rather than hoping that they will benefit from the "trickle-down" effect through the human services agencies. The savings in administrative costs alone would be enormous. Untold millions of dollars would be freed for individual use.

Another approach involves limited-purpose vouchers, which insure that assistance is used for appropriate purposes. We have already moved strongly forward in this area with the Basic Education Opportunities Grants program. Now, disadvantaged but otherwise qualified youngsters will be able to shop for a college that meets their needs. No longer will they have to go hat in hand in search of scholarships.

While the problems we face are complex, and their solutions difficult, we at last know what we must do:

- We must develop an income support system in government that makes sense. It must be fair, effective, and not work at cross purposes with itself.
- We must end the fragmentation of our human resource system. That means consolidating aid into block grants or something similar. It means decentralizing federal agencies. We now are looking hard at each of our programs.
- We must build into our intergovernmental relationships and in the voluntary sector a capacity to deal with human need in a comprehensive way. This means rebuilding part of government so that we have both vertical and horizontal linkages between and among Federal, State, and local governments.

There is only one way in which we can do all these things effectively. That is, *together.* It will do little good, indeed, if we "fix" only one part of our system of providing human services. That one "fixed" part, then, would not match all the other parts, and we would be courting chaos. When we have done these things, we will not only be helping people better, we shall have built a better and a stronger Nation.

Mr. Carlucci is Under Secretary, Department of Health, Education, and Welfare. This article is based on a paper he presented in 1973 in Dallas to the National Association of Counties.

Yes I can

After my accident, I had to start all over again.
I learned a new skill, and now I'm supporting myself.
I wouldn't have it any other way.

How Work Incentives Affect Welfare Rolls

BLANCHE D. COLL

Substitution of work for welfare to bring about a substantial reduction in the numbers of persons receiving public assistance has been a major national goal for almost 10 years. Although it is not unrelated to dependent blind and handicapped persons, the main effort to restore economic independence has been directed toward the employable recipients of Aid to Families with Dependent Children (AFDC). There are about 3 million adult AFDC recipients—mostly women. They are the parents of 8 million children. Over the past 15 years the number of persons receiving AFDC has increased fourfold. The increase in expenditures has been even sharper, from approximately $700 million in fiscal year 1957 to more than $7 billion in 1973.

Inclusion of the AFDC program in the Social Security Act of 1935 was the culmination of a long campaign on the part of social workers and reform groups to give destitute children the same opportunity for a mother's full-time care in the home as more fortunate children have. In 1940 married women with husbands present in the home accounted for only 15 percent of working women. Today 42 percent of this group are working. Although some experts claim that a mother's working has adverse effects on very young children, it is being done increasingly in our society. Almost one-third of wives with children under 6 are working today, compared to less than one-fifth a decade ago. In light of these economic and social changes, work for AFDC mothers seems to many an acceptable answer to the "welfare crisis." This conviction was affirmed by the Work Incentive (WIN I) program, established under the 1967 amendments to the Social Security Act. Within 4 years the amendments governing WIN had been changed significantly. The program then became known as WIN II.

WIN I could have been instituted by a State any time after April 1, 1968, but in no case later than July 1, 1969. The law contained several provisions intended to obviate known barriers to the employment of AFDC mothers. Day care for preschool age children and suitable arrangements for afterschool hours for other youngsters was to be assured. Training, either institutional or on-the-job, was to be given those women who lacked skills needed for immediate placement in employment.

To make working worthwhile, States were also required to allow the employed welfare recipient to keep $30 plus 1/3 of monthly earnings before recalculating the assistance payment. This "earnings exemption" or "earnings disregard" was deemed essential in encouraging recipients to choose work rather than welfare because many States had heretofore deducted the full amount of earnings from the assistance payment. In addition to the earnings disregard, States were expected to follow their previous practice of disallowing certain expenses related to work.

Responsibility for administering the WIN program was divided between the Departments of Health, Education, and Welfare and of Labor. State welfare departments were to refer all "appropriate" persons to State manpower agencies which would in turn place them in jobs or in job training. Certain persons, for example, the aged and infirm, or children under 16 or attending school full time, were not to be referred to the employment agency. But in failing to define "appropriate" further, the law left the welfare agency and the welfare recipient with a great deal of latitude to opt for or against entering the labor force.

In the 24 States that grant AFDC assistance to unemployed fathers, men are eligible to participate in the WIN program. But since unemployed fathers account for only 4 percent of adult recipients of AFDC, success of the program revolves around women recipients.

However acceptable the concept and however great the effort, the shift from dependency to self-support for these women and their children was and remains extremely difficult to bring about. Just why is made clear in statistical reports and research studies sponsored by the Departments of Labor and HEW. Now, almost 5 years since WIN started, it is instructive to examine some of these findings in the light of program results.

Welfare mothers are about equally divided as to whites and blacks. Nearly all of them are in the working years, with less than 10 percent under age 20 and only 2 percent over 55. Many are poorly educated. Although more than 60 percent of them have attended high school, only 26 percent are graduates.

Like other American women, most welfare mothers have worked for wages at one time or another. In fact, a good many work while receiving public assistance. A count taken in 1967, before WIN became effective, indicated that about 13 percent combined work and welfare. However, this figure greatly underestimated the welfare recipient's attachment to the labor force. Exactly how many combine work and welfare during the course of a year, for example, is not known, but data from a number of pre-WIN studies pointed to around 30 percent nationwide.

There were large regional variations. In 20 States where it is the practice to grant less than the full standard of need but to allow earnings up to that standard to be retained, many more women combined work and welfare than in States with higher assistance payments. This fact seemed to augur well for the effectiveness of an earnings disregard. By contrast, it said something less encouraging about the ability of these women to become self-supporting. To remain eligible for welfare payments, even though working, meant that their earnings were very low. And, as would become evident in time, there were other serious barriers to attaining self-support or even to working at all that the WIN program did not, or could not, address.

Many of these barriers were identified in a study (see note 5) conducted for SRS shortly after the inception of WIN. This study aimed to find out from the women potentially affected what their circumstances were, and, most important, what their intentions were, in regard to working outside of the home. In the early months of 1970 and again the following year, a total of 2,425 AFDC mothers living in 10 cities were interviewed.

As expected, the age, race, and educational attainment of the women corresponded closely to the AFDC group as a whole. About a third of their households were small, with only 1 or 2 children; another third were medium in size, with 3 or 4 children. The rest were large families. Many of the children were very young. Almost 60 percent of the women interviewed had children under 6. Both family size and age of children are crucial to success or failure in working one's way off welfare.

When first interviewed in 1970, 25 percent were working either full or part time; another 20 percent reported they were looking for a job. When reinterviewed, the overall situation was about the same—24 percent were working. Actually, more work activity took place than these percentages indicated. During the year or more intervening between the first and second interviews, 35 percent had earned something—15 percent by working all of the time and 20 percent by working some of the time.

With few exceptions, though, the jobs held were in occupations at the bottom of the economic ladder. Almost 60 percent were service workers—16 percent of these in household service. About one-third either had clerical jobs or were doing light factory work. A few were saleswomen. Only 3 percent employed were in the better paid professional, technical or kindred occupations.

To be sure, hundreds of thousands of women work in just such jobs, with earnings around the minimum wage, and never have to apply for public assistance. For the most part, however, these women are secondary wage earners who supplement a husband's earnings. Not so the AFDC mother, who, for one reason or another—marital breakup in about half, illegitimacy in more than one-fourth of the cases—is left without adequate support by husband or father. Eighty-eight percent of the women who had worked some of the time and 85 percent of those who worked all of the time were still receiving welfare when reinterviewed.

What of the much larger number of women (65 percent of those interviewed) who did not work at all? What were their reasons for not working? What were their expectations for the future? In view of their ages, a surprisingly large number (44 percent) said they were unable to work because of illness, surgery, accident, or physical disability. And although most of them were receiving medical treatment, they expressed a great deal of pessimism about recovering sufficiently to take a job.

These particular women were not asked to specify their disabling condition, but data from other studies tend to confirm the presence of a great deal of serious chronic illness and impairments among AFDC mothers: obesity—due to high starch diet—heart trouble, arthritis, tuberculosis, female disorders, hypertension, and varicose veins. Such ailments pose a major barrier to the employment of perhaps one-third of these women because so many of them can qualify only for jobs requiring physical exertion.

The necessity to stay home to care for children—given as the reason for not working by about half—was presumably invalidated by the guarantee of child care under the WIN program. However, this guarantee was not absolute, but provisional, namely, no AFDC mother would be referred for work unless child care was assured. Nationwide, there was a shortage of day care facilities. Most of the working AFDC mothers interviewed had made their own arrangements with relatives or friends and reported that they preferred this type of child care to what might be offered in more formal settings.

Poor health and need to care for children clearly emerged as the foremost barriers to working perceived by these AFDC mothers. Also important, at least for the early stages of the WIN program, was the widespread failure to comprehend the advantages of going to work, particularly the fact that some of the earnings would be disregarded in computing the assistance payment, and, therefore, the family would have more money at its disposal.

The first phase of the WIN program—usually referred to as WIN I—began on a limited scale in August 1968, came into full operation in July 1969, and was replaced by a revised program—WIN II—on July 1, 1972. The results of WIN I were disappointing in terms of numbers enrolled as well as numbers who completed training and/or got jobs. In the roughly 3 1/2 years from August 1968 through April 1972, a total of 385,100 persons, about 10 percent of the adult caseload, were enrolled in WIN. Although they comprise 97 percent of the adults, women accounted for only 60 to 70 percent of this total. About one-fourth of the men and women enrolled (3 percent of the adult caseload) had been placed in employment by April 1972. Slightly more than half of those enrolled had dropped out, many of them for "good cause" such as illness, pregnancy, or need to care for family. The rest remained in training.

Job opportunities for women were mainly confined to clerical and sales work or service occupations, with some openings in the social welfare and health fields. Pay was low: in clerical and sales work, the average hourly wage was $2.18; in service occupations, $1.92; social and welfare work, $2.43; medicine and health, $2.55.

In urging changes in the WIN program, members of Congress called attention to the difficulty of defining the term "appropriate," which resulted in great variation among State

welfare departments in referrals. Sponsors of amendments also criticized the extensive use of institutional training, particularly when such training was given without due regard to existing demand for skills.

Under WIN II amendments, all references to "appropriate" were eliminated. Instead, all applicants for and recipients of AFDC were required to register as a condition of eligibility, with, of course, certain exemptions. With two important differences, these exemptions were identical to those allowed under WIN I. WIN II specifically exempted women caretakers of children under 6, although these women were free to volunteer for the program. WIN II also exempted women caretakers if the father or other male relative was in the home and eligible for participation.

WIN II contained both a carrot and a stick. States could claim federal reimbursement for 90 percent of every dollar spent on services. This included salaries of staff in the Separate Administrative Units established to work exclusively with registrants and their job-related problems, and for services such as day care. Under the penalty of possible loss of funds, States were required to refer at least 15 percent of registrants to the manpower agency.

The law also stipulated the order in which persons were to be served by the manpower agency. The highest priority was to be given to unemployed fathers; then to volunteer mothers; third, other mothers and pregnant women under age 19; fourth, nonexempt dependent children and relatives; fifth, all others. Labor Market Advisory Councils with representatives from labor, industry, and public service were to identify jobs available or anticipated. Direct placement in jobs was preferred to training. Employers were allowed tax credits for hiring WIN participants. Not less than one-third of WIN funds must be expended for on-the-job training (for which the employer was reimbursed) and public service employment.

A review of activities under the WIN II program during the first full year of operation, from July 1, 1972 to July 1, 1973, reveals some striking differences as well as some striking similarities to WIN I. The first big difference concerns the number of participants: 354,000 persons, almost as many as had been enrolled in 3 1/2 years in the earlier program, participated in 1 year of WIN II.

Impressive also was the number of persons placed in unsubsidized employment. Such placements totaled 137,000, again more than were similarly placed in the course of WIN I. Institutional training was greatly reduced and on-the-job training increased, although on-the-job training was largely confined to men because of the reluctance of employers to hire women for jobs suited to such training.

When, however, WIN II is evaluated against the basic goals of the program, a substantial reduction in the welfare rolls and in welfare costs, the result is not very different from WIN I. Although WIN II participation was higher, the number of persons represented only 12 percent of the adult caseload, and those placed during the year only 4 percent. More than one-third of the participants dropped out and returned to the welfare rolls because of a change in their situation that made them exempt. A large number, almost half, left the program and also left the welfare rolls for reasons not directly connected with WIN.

Women continued to be placed in service jobs or clerical and sales occupations, although about 10 percent were in light factory work, such as textiles. The entry hourly wage for all jobs for women was $1.87; for men, $2.58. Of the 65,235 men and women who "completed job entry" (held a job for 90 days after placement), 34,574 or 52 percent were earning enough income to leave the welfare rolls. As would be expected, however, women were not nearly as successful as men in working their way off welfare. With a participation rate of 70 percent women, only 14,502 or 41 percent of the women completing job entry became independent of welfare. The number of men able to go off welfare was 20,221, 59 percent of those completing job entry.

The difference is partly due to higher earnings by men. Probably the more important determinant is the HEW regulation requiring men who work more than 100 hours a month to be dropped from the rolls, a requirement that also nullifies the earnings disregard. The earnings disregard has, in fact, tended to reduce the number of women terminated

from AFDC because of employment. In States with relatively high assistance payments, the family income of a working AFDC mother can theoretically go quite high before the break-off point. In Michigan, for example, with a basic grant of $316 for a family of four, gross earnings could reach $663 monthly. Before the introduction of the disregard, the break-off point would have been $395. Since the earnings of Michigan women in the WIN I program averaged $353, many remained on the rolls, though with reduced welfare payments.

To be sure, some savings will result even though the earnings of an AFDC mother continue to be supplemented by public assistance. Whether such savings are offset by administrative and other costs connected with the WIN program is an open question slated for investigation. This article has not been concerned with this question, nor has an attempt been made at cost-benefit analysis which would include an examination of the social and psychological aspects of work and work incentive programs for AFDC mothers.

General economic conditions, which in turn affect demand for labor, have an important bearing on the relative success of manpower programs such as WIN. When demand for labor is high and manpower scarce, as in wartime, women are hired to fill jobs traditionally reserved for men. In a normal market or when unemployment rates are up as they have been recently, employers prefer men for jobs on the assembly line or in construction. Such jobs do not require much education but often physical strength and some skill. They pay better than service jobs because of the skill requirements and because of a high degree of unionization. Efforts are being made by representatives of the WIN program to open up more of these jobs to women. For the immediate future, however, the male-female earnings differential is one of the major barriers to large numbers of AFDC mothers. Other barriers, not insurmountable, to be sure, but not easily overcome, are the poor health of many of these women and the presence of so many very young children in the home.

Miss Coll is a Social Science Analyst, Income Maintenance Research and Demonstration Branch, Office of Research and Demonstrations, SRS.

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Civil Rights Victories for the Handicapped-I

FRANK LASKI

Handicapped persons are in court. They are in courtrooms throughout the land asserting their rights under the U.S. Constitution, Federal and State statutes, including their right to services from the public sector. In increasing numbers, they are finding the judicial branch of government an effective forum to secure rights long denied.

Developmentally disabled and multihandicapped children have won significant victories on the right to a free publicly supported education. Mentally disabled persons have established constitutional standards for adequate treatment and habilitation. Physically handicapped persons have secured judicial enforcement of their right to access to public transportation and public buildings.

Favorable decisions have been rendered in regard to entitlement to minimum wage and classification and placement procedures for specialized education. Litigation on employment discrimination and rights to community services are on the horizon.

Legal action by and on behalf of handicapped persons is not only producing a direct impact on access to services but is also influencing legislative and administrative decisions on allocation of human service resources. It will ultimately lead to new relationships among handicapped citizens, service providers, and the community at large.

The leading cases vindicating the rights of handicapped citizens have been widely reported and commented upon in legal journals,[1] professional publications,[2] and the public press. The status of selected cases is reported periodically by various organizations.[3] This paper will not detail the factual circumstances and legal theories of the cases. Rather it will offer a brief description of selected aspects of certain cases in order to provide a basis for analyzing the implications of current and pending legal action on rehabilitation programs.

By focusing on legal developments in other service systems, some perspective may be gained on legal rights of handicapped persons in the rehabilitation process. With some idea of legal trends, State rehabilitation administrators and planners cannot only prepare to insure that internal programs and procedures guarantee the rights of handicapped clients under law, but should also develop plans to take the initiative in assisting handicapped persons to secure due process and equal protection in all dealings with employers and public and private service agencies.

First some consideration of the

legal action to date in "right to education," "right to treatment," and "right to barrier-free environment."

Pennsylvania Association for Retarded Children (PARC) v. *Pennsylvania*[4] was the first case in which a federal court explicitly recognized the concept of equal access to educational opportunity for handicapped children. This civil rights class action, brought by *PARC* and 13 mentally retarded children on behalf of all mentally retarded persons excluded from schooling, directly challenged Pennsylvania statues which denied education to mentally retarded deemed uneducable, or unable to profit from school, or to those persons not of a mental age of 5, or those outside compulsory school age.

Expert testimony so overwhelmingly demolished the factual underpinnings of the statutes that a consent decree was negotiated in which Pennsylvania acknowledged its responsibility to provide free public education and training to all children. On May 5, 1972, the three judge federal court approved the consent decree and permanently enjoined Pennsylvania education officials and local school districts from denying or postponing a free public program of education and training to any of the Commonwealth's mentally retarded children.

In its order, the court noted: ". . . all mentally retarded persons are capable of benefiting from a program of education and training; that the greatest number of retarded persons, given such education and training are capable of achieving self-sufficiency, and the remaining few . . . are capable

of some degree of self care; . . . whether begun early or not, . . . a mentally retarded person can benefit at any point in his life and development from a program of education and training."

Although PARC counsel set forth the constitutional grounds for the right to education when requesting a three judge panel and again when a school district challenged the jurisdiction of the court, the constitutional issues were left for resolution in a subsequent case, *Mills* v. *Board of Education of District of Columbia.*[5]

The *Mills* plaintiffs were classified as brain-damaged, hyperactive, epileptic, mentally retarded, mentally retarded with orthopedic handicap, and, on the basis of these labels, excluded from D.C. educational programs. On behalf of all children who had been excluded or otherwise deprived of access to publicly supported education, the plaintiffs challenged their exclusion and the procedures and practices by which D.C. education and social service officials denied children public education.

Basing its decision on the due process and equal protection clauses of the U.S. Constitution, the *Mills* court ordered that: "no child eligible for a publicly supported education in the District of Columbia public schools shall be excluded from a regular public school assignment by a rule, policy, or practice of the Board of Education of the District of Columbia or its agents unless such child is provided (a) adequate alternative educational services suited to the child's needs, which may include special education or tuition grants,

and (b) a constitutionally adequate prior hearing and periodic review of the child's status, progress, and the adequacy of any educational alternative."

On the strength of the constitutional holding, the *Mills* court put the final nails in the coffin of the concept of uneducability, making its ruling applicable regardless of degree of type of exceptionality and regardless of the fiscal impact on the school system. Part of the August 1, 1972, decree reads: "The District of Columbia shall provide to each child of school age a free and suitable publicly-supported education regardless of the degree of the child's mental, physical or emotional disability or impairment. Furthermore, defendants shall not exclude any child resident in the District of Columbia from such publicly-supported education on the basis of a claim of insufficient resources."

As in *PARC*, *Mills* detailed the due process requirements which must be followed in placement, reassignment, or transfer among educational programs. Parents are entitled to advanced notice of placement and reasons for placement; right to a hearing by an independent hearing officer, including right to legal counsel or other advocate, a record of the hearing, right to inspect records, present evidence, cross examine witnesses, and right to appeal.

Cases patterned upon *Mills* have been filed in at least 30 States. Favorable decisions have been rendered in Louisiana, New York, and Wisconsin. Before the close of the year, final action is expected in Colorado, North Dakota, and a number of other States.

Some of these cases are based on State constitutional provisions and statutes; however, all rely to some extent on the equal protection and due process clauses of the Fourteenth Amendment.

The constitutional doctrine has been best explained by Attorney Paul Dimond. He writes: "First, the unjustified exclusion of any child from all public schooling denies to that child the equal protection of the laws when the State makes the opportunity freely available to other children. Second, the operation of our unfair procedure in the stigmatization by public authority of any person or the denial to him of any public good denies the process due each person under the Fourteenth Amendment. Such a stigmatization and denial is involved in labeling children as 'exceptional,' 'retarded,' or 'handicapped' and placing them in special classes, or excluding them from schooling entirely. These two rights, equal protection and due process, merge to form the emerging constitutional right to an education, which guarantees to every child a minimally adequate publicly supported educational opportunity."[6]

* * *

Like right to education, right to treatment is a shorthand for a merger of rights guaranteed by the due process and equal protection clauses of the Constitution. The Eight Amendment's prohibition of cruel and unusual punishment and the Thirteenth Amendment's guarantee of freedom from involuntary servitude have also been used to bolster the case for the creation of a right to habilitation and treatment.

The right to treatment emerged in cases challenging the confinement of civilly committed mentally ill patients. It was argued that if the need for treatment provides the rationale for confinement, then the patient must actually be treated or released. This argument was given some recognition by courts in the District of Columbia and Massachusetts in the mid sixties, but it had little impact on patients or mental health service providers until raised in *Wyatt* v. *Stickney*[7] and applied to all mentally ill and mentally retarded persons confined in public institutions in the State of Alabama.

In regard to the mentally ill, Chief Judge Frank Johnson stated that committed patients "unquestionably have a constitutional right to receive such individual treatment as will give each of them a realistic opportunity to be cured or to improve his or her mental condition."

As to the residents of Partlow State School, it was held that "the mentally retarded have a constitutional right to receive such individual habilitation as will give each of them a realistic opportunity to lead a more useful and meaningful life and to return to society."

Initially, the court ordered the State to develop a plan for treatment and habilitation. However, further relief was required by Alabama's failure to improve the conditions which expert testimony had shown to be inhumane and devastating to resi-

dents—conditions which were characterized by lack of safety, lack of privacy, malnutrition, exploitation of patient labor, solitary confinement, excessive use of restraints, inadequate staffing, lack of individualized programs, deterioration of physical and mental conditions, brutality, and patient deaths.

To rectify these conditions and implement the right to treatment, the *Wyatt* court not only set down the general parameters of minimum treatment (*i.e.*, a humane psychological and physical environment, a qualified staff in numbers sufficient to administer adequate treatment, and individualized treatment plans) but also set forth in detail the minimum constitutional standards for adequate habilitation of the mentally retarded and adequate treatment of the mentally ill. To monitor implementation and guarantee that residents be afforded constitutional and humane treatment, the court directed the establishment of a human rights committee and retained case jurisdiction.

The *Wyatt* court, just as *Mills*, faced the funding question head on by indicating that lack of operating funds could not justify withholding habilitation. Chief Judge Johnson stated: "in the event, though, that the Legislature fails to satisfy its well-defined constitutional obligation and the Mental Health Board, because of lack of funding or any other legally insufficient reason, fails to implement fully the standards herein ordered, it will be necessary for the Court to take affirmative steps, including appointing a master to ensure that proper funding is realized and that adequate habilitation is available for the mentally retarded of Alabama."

The existence of a judicially enforceable constitutional right to treatment and the approach to implementation taken by Judge Johnson in *Wyatt* was rejected by another federal court in *Burnham* v. *Department of Public Health of Georgia.*[8] *Wyatt* and *Burnham* have been joined on appeal before the Fifth Circuit. The reasoning of *Wyatt* was accepted fully in *Welsch* v. *Likins*, No. 4-72-Civ. 451 (D. Minn.) where U.S. District Judge Earl Larson found a right to care and treatment under the due process clause of the Fourteenth Amendment and a comparable right under Minnesota statutes.

In other cases, federal courts in New York and Massachusetts, while avoiding the question of the nature of a constitutional right to treatment, have granted relief in line with minimum enforceable standards. In these subsequent cases on institutional treatment, rights secured and relief provided has applied to persons admitted voluntarily as well as to those committed. In addition, mental health and retardation administrators are defendants in right to treatment suits in Nebraska, Illinois, North and South Carolina, Missouri, and Tennessee.

* * *

The right of handicapped persons to be free from architectural and transportation barriers has not received as much judicial attention as treatment or education; however, some important legal principles are being established. Physically handicapped plaintiffs challenging barriers have raised sound arguments based on federal statute and various constitutional provisions.

The most significant ruling to date arose from the nonfeasance of Washington Metropolitan Area Transit Authority officials responsible for planning design and construction of the Metro subway system for the Nation's Capital.

In 1970, Congress enacted P.L. 91-205 which added clarifying amendments to the Architectural Barriers Act of 1968 (P.L. 90-480) mandating that subway stations, surface stations, and other structures of Metro be accessible to the handicapped. The original plans for an Adopted Regional System agreed to under the terms of a Compact among D.C., Maryland, and Virginia, made no provision for accessible facilities (capital costs covered escalators rather than elevators). After passage of P.L. 91-205 no changes were made, contracts were let, and construction continued without provision for elevators.

The Washington Urban League, the Paralyzed Veterans of America, the National Parapalegia Foundation, and Mr. Richard Heddinger filed suit in U.S. District Court petitioning for a declaration that Metro was in violation of federal law and an injunction preventing Metro from making further expenditure of construction funds or taking any other action that would make the installation of elevators more difficult or costly.[9] A preliminary injunction was denied, based partially on the public interest in

maintaining the construction schedule and upon the belief that Metro officials would take steps to redesign stations and install elevators. However, Metro officials consistently maintained that the 1970 amendment to the Architectural Barriers Act was simply an authorizing statute and an appropriation of $65 million earmarked for the handicapped was required before action on installation of elevators could be effected.

This stance puzzled the Chairman of the U.S. Senate Committee on Public Works, Jennings Randolph. "I am not aware," he wrote to the General Manager of Metro, "that the rapid transit system was to be financed as a program for the physically fit and a program for the handicapped. It is my understanding that the entire system will be financed in large part from the taxes collected from all taxpayers and is to be constructed so that it can be used by all of the taxpayers who want to use it . . ."[10]

For over 3 years, Metro officials held to the view that any expenditure of funds for the handicapped (even funds raised from sale of revenue bonds authorized subsequent to the Congressional mandate that Metro be accessible) would be a diversion of funds from the Adopted Regional System. This position changed only upon the issuance of an injunction by Judge William Jones, preventing Metro from opening any stations for use unless and until stations were equipped with inclined elevators.

Since the Metro case centered on a question of statutory interpretation, the defendants' arguments and actions, interpreting handicapped persons out of the transportation system, are instructive as to the price handicapped citizens have had to pay for reliance on legislative measures to achieve reform and augment services. The history of discrimination in generic programs leading to specialized legislation to provide for handicapped persons, requiring specialized funding, which may or may not be provided, has led to some peculiar attitudes and assumptions relating to rights of handicapped under statute.

In reviewing implementation of State statutes, it is possible to derive two widely practiced rules of construction which, until recently, have gone unchallenged. First, that general laws providing benefits and protection to all citizens implicitly exclude handicapped persons. Second, that mandatory language in specialized legislation is something less than mandatory when applied to handicapped persons. For example, a 1971 NARC study found no significant relationship between State laws mandating education for retarded children and actual participation of such children in educational programs. Another serious discrepancy between State law on the books and law in action relates to mandatory provisions of interpreters to deaf persons in judicial proceedings.

Architectural barriers legislation is yet another example. All but a few States have statutes on architectural barriers. While provisions vary from State to State, coverage is generally limited to new public buildings, enforcement is diffuse and weak, and the

statutes are riddled with waiver clauses. Thus, it is important for handicapped persons to establish that these statutes are in no way preemptive—that they do not define the limits of right to access to public buildings and accommodations. An initial and significant step in this direction was taken in the lawsuit of *Friedman* v. *County of Cuyahoga.*[11]

Friedman, an attorney confined to a wheelchair, attempted to enter five county buildings in Cleveland, four housing courtrooms. He could not enter any of them without assistance. He filed a class action suit in the Court of Common Pleas for the County of Cuyahoga, seeking a declaratory judgment as to right to access and injunctive relief. Since the buildings were not covered by the Ohio architectural barriers statute, the legal action was based on rights guaranteed by the U.S. and Ohio Constitutions.

The plaintiff argued that the acts of the county commissioners in maintaining barrier laden buildings amounted to: denial of access to the courts, denial of access to a seat of government in derrogation of the right to free petition, denial of right to travel and freedom of movement, and denial of equal protection in that the barriers unjustifiably limited equal employment opportunity. These infringements on constitutional rights, Friedman asserted, placed a burden of affirmative action on the county commissioners to provide access to all handicapped citizens.

The lawsuit was resolved by agreement of the county commissioners to install ramps and insure accessibility in all existing county-owned buildings. The judicially approved consent decree also provided that all county buildings constructed in the future must conform to accessibility standards.

The approach of the Friedman case, with its reliance on a number of fundamental constitutional rights which have been consistently and vigorously protected by the courts, expands upon and illustrates the validity of a point made by Dean Thomas Shaffer regarding the mentally disabled. It is that we do not need a bill of rights for handicapped citizens. All we need is to treat handicapped persons as if they were people and then apply to them the same Bill of Rights we apply to everyone else.[12]

Because of space limitations, this article will be continued in the June edition of "The Social and Rehabilitation Record." In that issue, the ramifications for rehabilitation of the cases discussed here will be reviewed.

Mr. Laski is a member of the Bar of Massachusetts. He is currently on the staff of the National Center for Law and the Handicapped.

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(2) See Lippman and Goldberg, *Right to Education,* Teachers College Press, Columbia University, 1973; Mental Health Law Project, *Basic Rights of the Mentally Handicapped,* National Association for Mental Health, Washington, D.C. 1973.

(3) Office of Mental Retardation Coordination, DHEW, *Mental Retardation and the Law,* Paul Friedman (ed.); Council for Exceptional Children, *Continuing Summary of Pending and Completed Litigation Regarding Education of Handicapped Children,* Alan Abeson (ed.).

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(10) Letter to Jackson Graham, General Manager WMATA, Jan. 4, 1971.

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EARLY SCREENING

MEDICAID IS FINDING AND TREATING THE HEALTH PROBLEMS OF CHILDREN IN ELIGIBLE LOW-INCOME FAMILIES.

The Administrative File

Each month the SOCIAL AND REHABILITATION RECORD will carry a listing of SRS administrative issuances for previous months. Over the course of a year, the RECORD will have presented a complete bibliography of administrative issuances for the year.

The following are the administrative issuances for the month of February 1974. (Abbreviations key: **PR**-Program Regulations; **PRG**-Program Regulations Guides; **PI**-Program Instructions; **IM**-Information Memoranda; **FSI**-Field Staff Information and Instruction Series; **AO**-Administrator's Office; **MSA**-Medical Services Administration; **APA**-Assistance Payments Administration; **CSA**-Community Services Administration; **RSA**-Rehabilitation Services Administration; **NCSS**-National Center for Social Statistics.)

When ordering reports, please specify the appropriate room number for the particular report: For NCSS reports, write NCSS Reports Clerk, Room 2620; for PR reports, write PR Reports Clerk, Room G-115B; for AO reports, write AO Reports Clerk, Room G-115B; and for all other reports, write Reports Clerk, Room 5219.

Send all requests with the appropriate room number to Social and Rehabilitation Service, U.S. Department of Health, Education, and Welfare, 330 C Street S.W., Washington, D.C. 20201.

APA-IM-74-6: Energy Crisis—Meeting Emergency Needs Under Federally Aided Assistance Programs (2/12/74)

APA-IM-74-7: Social Security Benefit Increases for 1974 (2/26/74)

AO-IM-74-29: Definition of "Incapacity" (2/1/74)

AO-IM-PR-10-15: Sterilization (2/6/74)

AO-IM-74-30: VR-SSI (2/11/74)

AO-IM-74-31: Continuing Cooperation Effort between the State Vocational Rehabilitation and Public Welfare Agencies (2/8/74)

AO-PR-10-11 (C-18); 40-6(C-1): Cost Sharing in Medicaid (2/13/74)

AO-IM-74-32: Joint Payee Procedure (2/12/74)

AO-IM-74-33: Proposed Regulations on Utilization Review Under Title XIX—Extension of Comment Period (2/12/74)

AO-PR-31-1 (C-1): Federal Sharing in Emergency Services at the 50% Rate (2/12/74)

AO-PR-10-15 (C-1): Deferral of Effective Date of Sterilization Regulations (2/12/74)

RSA-IM-74-43: Program Evaluation in State Vocational Rehabilitation Agencies (2/4/74)

RSA-IM-74-44: Number of Rehabilitations; July 1 to December 31, Fiscal Years 1973 and 1974 (2/27/74)

RSA-PI-74-21: Distribution of Funds Made Available under the Beneficiary Rehabilitation Program (Trust Funds) for Fiscal Year 1974 (2/8/74)

RSA-PI-74-22: Funding of Innovation and Expansion Program—Fiscal Year 1974 (2/14/74)

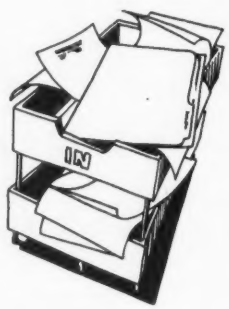
CSA-PI-74-7: State Plan Amendment to Provide for Meeting Special Requirements Relating to Sterilization (2/6/74)

CSA-PI-74-9: Reallotment of FY 1974 Child Welfare Services Funds (2/21/74)

NCSS-PI-18: Edit Error on Report on Public Assistance Applications, Cases Approval and Cases Discontinued, SRS-NCSS-2079 (2/1/74)

NCSS-PI-74-19: Report on Administrative and Legal Actions on Allegations of Suspected Fraud Under Medical Assistance Program Form SRS-NCSS-119 (2/12/74)

NCSS-PI-20: Report on Children for Whom Adoption Petitions Were Granted During the Year, Form SRS-NCSS-281 (2/20/74)



NCSS-IM-74-6: Summary Listing of Forms to be Submitted to NCSS (2/7/74)

MSA-IM-74-11: Study of Early and Periodic Screening, Diagnosis, and Treatment Program (2/21/74)

MSA-PI-74-5: Preprinted State Plan for Title XIX—Amendment to provide for meeting requirements relating to sterilization procedures for which payment is made under Medicaid. (SRS Program Regulation 10-15, 45 CFR 205.35, Feb. 6, 1974) A revised page 10 of the preprinted plan is enclosed. It is to be submitted to the appropriate Regional Office by April 22, 1974. (2/4/74)

MSA-PI-74-6: Preprinted State Plan for Title XIX—Amendments to provide for meeting regulatory requirements under section 208, P.L. 92-603, relating to cost sharing. Attached are revised pages to be submitted by April 15, 1974. (2/28/74)

MSA-PI-74-7: Preprinted State Plan for Title XIX—Amendments to provide for meeting regulatory requirements relating to skilled nursing facility and intermediate care facility services. Attached are revised pages.

MSA-PIM-74-10: Federal Financial Participation for Payments for Reserved Beds in Long Term Care Facilities (2/25/74)

MSA-FSI-74-47: California Child Health Disability Prevention (2/4/74)

MSA-FSI-74-48: Inventory of Use of Prior Authorization by State Medicaid Agencies (2/21/74)

MSA-74-49: Contract SRS-73-61, Study of Cost Differentials between Skilled Nursing and Intermediate Care Facilities—Distribution of the Final Report (2/28/74)

Industry's Commitment to VR

ANTHONY DE SIMONE

The cliche that "you've gotta go where the action is" perhaps typifies nicely what the Rehabilitation Services Administration of SRS has done with its Projects With Industries grants program. Here the traditional process of training has been brought to industry on industry's turf and with close liaison with the rehabilitation staffs. In this manner, the rehabilitation of handicapped people is being actively engaged in by industry as well as by professional rehabilitation persons. Cooperating firms are no longer just the end product of rehabilitation, they are the beginning and middle, as well. They are active partners because they want to be, and not because of altruistic or for profit purposes.

The following quotation is taken from *Work In America,* the Report of a Special Task Force to the Secretary of HEW. The report was made in 1973; it was prepared under the auspices of the W. E. Upjohn Institute for Employment Research. It shows the symbiotic relationship that must exist between business and society:

"In addressing the question of the employers' obligations to society, to stockholders, and to workers, [the businessman] must see them as intricately interrelated. One cannot, in effect, serve society at all if he does not serve its people. One cannot serve shareholders effectively if he does not act to make business itself an agent for human growth and fulfillment. For unless the businessman-employer . . . recognizes this as a minimal obligation, he will in the long run (and more likely in the short term) participate in the destruction of the very instrument from which stockholders draw nourishment.

"The extension of corporate responsibility goes beyond *'Industrial Efficiency'* which is defined in its usual economic sense: The goal of an enterprise is to obtain maximum output at a given level of costs (or a given level of output at a minimum cost). In optimizing costs and outputs, all substitutions (trade offs) are internal to the operation of that enterprise. Labor and Capital—including intellectual, managerial, and the accumulation of skills, as well as physical capital—are substituted for one another to achieve efficiency for the firm, without regard to external effects.

"*Social Efficiency* draws on the economic notion of externalities, which recognizes that the production of goods or services by a firm may result in costs or benefits that occur in society and which are not accounted for in the internal audit of any firm or all firms together."

The use of these two terms (social and economic efficiency) serves to illustrate in simple conceptual terms issues that have faced management since the day of the "Great Society" programs advanced during the Johnson Administration. Issues of minority employment, affirmative action programs, and many Department of Labor-sponsored projects designed to stimulate industry to become sensitive to the external factors in the community. Indeed, conceptually, it may be possible that a company may be socially efficient but industrially inefficient. In point of fact, this is a

dilemma that faces the administrator of sheltered workshops whose major objective it is to graduate his best trainees to the community, thereby losing his most efficient and productive employees.

In reality, however, profitmaking organizations have a clear responsibility to the shareholder. The concept of industrial efficiency, therefore, seemingly directs the policies of businessmen. However, there is a growing volume of evidence that the interrelationship between social and industrial efficiency and the achievement of a balance between the two leads not only to keeping the shareholders happy but also to worker satisfaction. Indeed the stereotyped image of a soulless industry has given away in many instances to companies who are sensitive to the needs of the community and to the need for their own workers to identify with a corporate image that demonstrates this in tangible ways.

Of the many government sponsored projects aimed at increasing employment among the disadvantaged in society, none have been better designed to reflect the necessary balance of social and industrial efficiency as Projects With Industry which are funded through the Rehabilitation Services Administration.

Contrasted with most manpower programs which pay for the total operational costs including a profit margin, Projects With Industry rely upon the inherent philosophy expressed so well as an extension of corporate responsibility in the community from which it draws its manpower. These concepts stress the importance of the cooperative partnership arrangement between Federal, State, and community-based rehabilitation programs. Federal funding is used for seed purposes, to assure the orderly development of entry evaluation and training programs for the handicapped to be provided with the assistance of rehabilitation specialists in the community.

Over the last 5 years, we have seen a number of these projects become a reality.

The placement of handicapped people in remunerative employment has been the heart and soul of the State-Federal program of vocational rehabilitation since its inception in 1920. Handicapped people placed in employment are no longer handicapped but have learned to cope with the disability. The placement process in VR has grown as a combination of art and science. And placement frustration comes primarily through negative attitudes toward the handicapped and through the nonavailability of jobs in the market place.

In New York, Commissioner Adrian Levy of the State Office of Vocational Rehabilitation has cooperated closely with my office and the Projects With Industry program both developing the project and in referral of clients in purchase of rehabilitation services, and in counseling and supervision of the client.

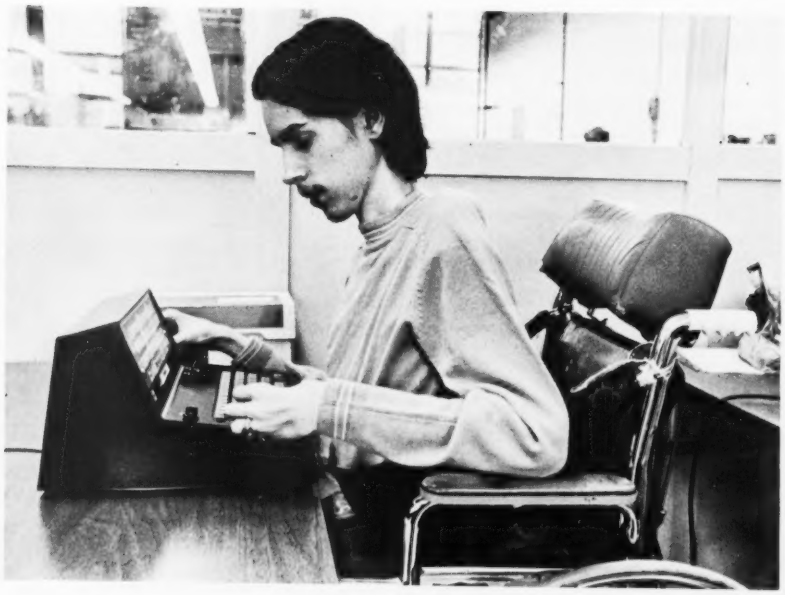
The Fountain House Model

Nine men, varying in ages from 22 to 58, are working as warehouse stock handlers. They are indistinguishable from other men loading and unloading large crates with hi-lo's and hand trucks. They are sweating in their labor as they exchange the kind of conversation that hard working men exchange. And, yet, among the nine men, they have spent 127 years in mental hospitals. Three of them have been in psychiatric hospitals for 25 years each.

The cost of hospitalization to the public was approximately $15 per day for 127 years, or a total of $700,000. But, as a group, they now earn $27,000 per year. Most of them had received custodial care only in the institution, a concept contrary to the principles of rehabilitation. This custodialism also makes it extremely difficult to reintegrate former mental patients into the world of work.

Fountain House, a New York City psychiatric rehabilitation center, has received a Project With Industry grant. It focusses on placing former mental patients into jobs in industry. They have been successful in negotiating group placements with many employers, including Host International of the Newarker Restaurant (Newark airport), CBS, Imports Sales Corp. (N.J.), Sears Fashion Distribution Center (N.J.), and Alexander's Inc., department stores in New Jersey and New York.

The transitional employment placement gives the former mental patient the opportunity to work along side other employees, earn the regular rate of pay, and develop confidence for future permanent employment. Supervision and counseling are pro-



vided by Fountain House staff who work on the job with the group until adjustments are satisfactory. After 3 to 6 months, depending on individual adjustment factors, some go on to other transitional experiences and others to individual, full time jobs.

In its December 1973 report, Fountain House officials note that there are seven group placements in operation. Their annual earnings exceed $200,000. The savings in the cost of custodial care when patients are provided the benefits of the Fountain House program demonstrate clearly the social and industrial efficiency that is possible in the cooperative effort between business and government.

The Human Resources Model

Still another approach to Projects With Industry brings together the skills and expertise of an internationally known rehabilitation center for the physically handicapped, Human Resources Center of Albertson, Long Island, New York, with the business and industrial community. Designed to stimulate social efficiency and to encourage employer involvement in the evaluation and training of physically handicapped, this model initiates the process of rehabilitation by carefully evaluating the client and then training him in preparation for placement at Human Resources. Such placements have been in banks, insurance companies, and computer service offices.

If necessary to insure the placement, minor modifications of architectural barriers and adaptations to the work station are possible at no cost to the employer's account.

Now in its 4th grant year, the project at Human Resources has cooperated with such companies as General Electric, Franklin National Bank, Insurance Company of North America, and others. It has demonstrated the "social efficiency" factor. For example, a recent report showed that if 38 physically disabled persons had not been employed through Projects With Industry, they would most likely be on welfare at a cost of $450,000 annually.

Instead they are earning with benefits $950,000 annually and repaying the cost of their rehabilitation through taxes at the same time, at the rate of $106,530 per year.

A major objective of this program is to encourage companies to accept the role of providing evaluation training and employment of the handicapped as a part of their regular operational policy. Then, with the assistance of the New York State Office of Vocational Rehabilitation and the consultation of Human Resources, these companies will be fulfilling the goal of Projects With Industry.

Placing the disabled in business is not an easy task and, until recently, it was the sole responsibility of the public and voluntary agencies. I believe that we have entered a new era, one in which the private sector of our society has demonstrated its willingness to be an active partner. The partnership is motivated not for the profit motive but because what is good for society is good for the private sector, as well.

Quoting from *Work in America* once more: "In humanistic and social terms, however, no one is 'inefficient,' and modern societies, recognizing this, find it worthwhile to provide some assistance when one is unemployed. But the assistance is generally very little, and the mental and physical suffering from unemployment quite large. The social efficiency model would assert that there are always jobs that need to be done in society, that the costs of unemployment are too high to be tolerated, and it is for people that employment exists, not the other way around.

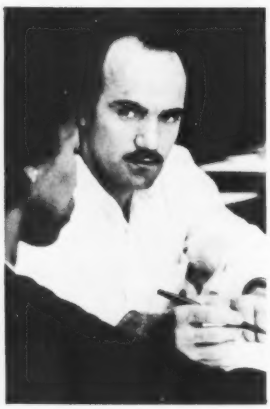
"For society, the main benefits from an increase in both the quantity and quality of jobs will be avoiding some of the very large costs now incurred by the present way we do business. These costs are not fully tallied in the annual reports of our corporations and bureaucracies; they are the costs of such job-related pathologies as political alienation, violent aggression against others, alcoholism and drug abuse, mental depression, an assortment of physical illnesses, inadequate performance in schools, and a larger number of welfare families than there need be. These costs are borne by the citizen and by society; they must be included in any systematic accounting of the costs and benefits of work in America. A precedent for this has been established in environmental policy; the precedent needs to be extended to social policy."

Mr. DeSimone is Associate Regional Commissioner for Rehabilitation, HEW Region II.

Successful Goal Planning with the Mentally Disabled

BARBARA E. MORIARTY

In an exciting 3-year research study, Dr. Peter S. Houts, a social psychologist, and Robert A. Scott, a psychiatric social worker, developed and evaluated a program to teach goal planning to mentally ill patients with a history of long term hospitalization. This group is often described



as lacking in motivation. Also, they often lack verbal skills, time perspective, and the ability to draw valid conclusions from available facts. These are the very characteristics important in acquiring the motivation to achieve.

Psychodynamics is the current choice of treatment, but in emphasizing the unconscious causes of problem behavior, it often overlooks healthy abilities. In psychodynamics, problems receive more attention than do potentials. This negative viewpoint is further strengthened by the perception of deviant behavior as a public nuisance.

In this context, psychodynamic's primary goal is eliminating disruptive and asocial acts. This is particularly true in large institutions where routine and order are so vital. In this setting, problems and crises receive attention more frequently than healthy behaviors.

In their positive approach, project staff at the Pennsylvania State University College of Medicine emphasized four themes: 1) understanding the debilitating effects of institutionalization, 2) working toward meaningful goals for both patients and sponsors, 3) setting goals which start where the patient actually is, and 4) making plans which acknowledge the patient's strengths and weaknesses and which spell out reasonable and specific steps to reach his goal.

The goal-planning model was tested in six separate studies: male former patients living in foster homes, male and female mental patients in two State hospitals, male mental patients in a VA hospital, and residents of a private nursing home, many of whom showed evidence of mental deterioration. These groups were chosen because the patients were receiving the same treatment program.

The studies followed an experimental design. Short and long term goals were devised, and deadlines were assigned to short term objectives.

Each group was randomly divided in half, with the control group continuing its regular program. Although patients were aware of goals, they received no organized institutional support in reaching them.

The experimental group received time to pursue its goals actively as part of therapy. Because of closer relationships and more intimate knowledge of daily behavior patterns, front line staff working directly with these patients developed the goal plans and were responsible for successful goal realization.

At deadline time, disinterested outsiders interviewed staff and patients to determine the extent to which the goals had been achieved. Ratings of client success were based on the Kiresuk and Sherman Goal Attainment Scale. Behavior categories ranged from "most unfavorable outcome thought likely" to "best anticipated success with treatment."

Statistical results are summarized in the final report. Essentially, they

show that goal planning procedures can have a substantial effect in accomplishing treatment objectives for patients, but staff commitment is necessary for this to happen.

Mental health workers and clients maintained a close relationship throughout the project. The teaching of goal setting through modeling was achieved in this setting. Modeling is particularly appropriate for the clients because it is accomplished in the same setting in which training occurs. Furthermore, modeling teaches the techniques of goal planning with a minimum of reliance on definitions and abstract concepts.

Training should affect patient initiative, planning, and performance. For example, the worker and the client discuss problems in adapting to the community. They examine whether or not the patient is setting reasonable goals, using feedback from his performance, considering obstacles, seeking help, and anticipating feelings upon reaching goals. Also, when the patient is learning social skills, such as budgeting, use of leisure time, or use of public transportation, the strategies of goal setting are practiced. Recreation therapy also provides opportunity for conscious practicing of motivation strategies by having patients set point goals to be earned and using feedback from past performances.

Finally, in place of the occupational, industrial, and educational therapy programs that were used with the control group, individualized plans were developed for the experimental group. Here each patient practiced strategies to achieve motivation in ways which were especially relevant for his adaptation to the community and employment. For example, a patient who could reasonably hope only for employment at rote tasks practiced attaining modest goals when working on rote tasks. A patient who could expect more responsible employment practiced strategies in achievement in organizing the work of other patients. Patients who tend to be overwhelmed when demands are made of them practiced reducing these demands to small, realizable goals.

Since this part of the program uses individual planning, the client might be involved in role playing, assignments carried out downtown, or short job assignments.

In goal planning, the commitment is to achieve behavior change, demanding accountability of both client and counselor.

Goal planning also provides data for constructive decision making about clients and programs. Because he is involved, the client has a personal commitment to the plan. And because of positive goals, client strengths are developed, then strengthened through rewards for accomplishments.

Program goals emphasize constructive use of patient time. Goal selection and implementation follow a precise pattern developed as the most conducive steps to rehabilitation. First, patient backgrounds are reviewed. This includes personal contact with persons living and working with the patient. Second, present behavior, attitudes, and vocational desires are assessed. Third, patient and professional agree on realistic and meaningful goals. Fourth, the professional prepares a treatment goal form. Fifth, the patient reviews, changes, or accepts the goals and plans.

Sixth, other mental health workers are told about the goals and plans. They are also advised about their involvement and role toward goal achievement. These workers may include visiting nurses, social workers, foster home sponsors, community

agency staff, etc. Seventh, staff write progress notes on each goal. Where appropriate, weekly subgoals help the patient maintain involvement and commitment. The overall plan monitor makes regular weekly assessments of progress by contacting patient and workers.

Eighth, goals are altered or changed when necessary. Ninth, at the end of the goal time allotment, progress is reviewed and outcome is evaluated. Based on the evaluation, new goals are then set.

In working with patients and mental health workers, project staff

identified five basic elements which should be included in rehabilitation programs for the mentally ill. Each is absolutely essential.

Involve the patient. The patient should participate in choosing goals. This is essential, not only because it is his right, but also because treatment cannot succeed without it.

This seemingly obvious point is often ignored, sometimes for "convenience" and sometimes through rationalizing that "the patient is too sick."

Set reasonable goals. The goals must be achievable. Staff must first identify patient strengths, then base the program on what he can do. Next, some reasonable improvement is called for, based on strengths identified.

The important thing here is gaining acceptance of goal planning and getting the patient in the right spirit. Once in the habit, the types of goals are more easily changed. Each small success leads to the setting of more complex goals.

Describe the patient's behavior when the goal is reached. Clearness is essential. On reaching a goal, staff or patient must be able to agree on its meaning. This also insures accountability, since there can be no question of whether or not the goal has been achieved.

The author should describe what the patient will be doing or how he should be acting when the goal is reached. Unfortunately, many mental health workers use vague, ambiguous language in their discussion of patients. Here are a few examples: "He should improve his self concept." "He should have a greater appreciation of his limitations." "He needs insight into his feelings."

Specifics are lacking in those examples. Unless we know how the patient should act when he has "greater appreciation of his limitations," we really know nothing. But even more important, the patient himself doesn't know!

Set a deadline. An achievement date should be agreed upon. If need be, it can be changed, but originally targeting a date is important. This provides a direction for the patient and helps in motivation. It also is a staff aid in working with the patient.

Spell out the method. Who will do what? Is the method stated clearly enough that another staff member could do the procedure after reading the rehabilitation plan? Assignment of responsibility aids both communication and accountability.

Training Materials

The project has developed several training booklets. Some 6,600 have been distributed as handouts during presentations at meetings, in consultations at different facilities, in training its own research staff, through mailings to persons prominent in mental health rehabilitation, and in answering public inquiries.

The goal planning procedures are currently being used in California's Atascadero State Hospital, Pennsylvania's Harrisburg Hospital, both its daycare and residence centers, Buffalo General Hospital Community Mental Health Center, Pennsylvania's Pickel Nursing Home, and Cumberland County Child Welfare, Minnesota's Rochester, St. Peters, Fergus Falls State Hospitals, and many other mental health facilities throughout the Nation.

The booklets are aimed at both patient and staff and are characterized by big print, expressive cartoon figures, and a simple repetitious approach. They emphasize clear language in writing goals, concrete descriptions of methods of achievement, and the setting of realizable goals. They are: *What Will Therapy Do for Me (or, if you don't know where you're going, you'll never get there!): A Guide to Setting Objectives in Mental Health Treatment Programs, Goal Planning in Mental Health Rehabilitation, Take A Small Giant Step: How You Can Set Resonable Goals for Yourself!,* and *Goal Planning Strategy for Problem Behaviors.*

In addition, a *Goal Planning Workshop* video tape has been prepared and field tested for inservice training of staff who are working directly with patients. An associate instructor uses the video tape, workshop exercises, and group discussions in leading a series of six 2-hour sessions. During this time, the 8 to 10 students practice developing four goal plans. A student's manual and an associate instructor's manual have also been prepared.

Findings

When goal planning is utilized to its fullest (*i.e.*, employing all five required steps), the patient's successes

in rehabilitation increase significantly in number and extent.

The staff's attitudes play a determining role in the success of the goal planning methodology. Where staff commitment and enthusiasm are missing, the benefits are negated and rehabilitation results strongly resemble those of regular treatment programs.

Neither sex nor premorbid history affect the patient's response to goal planning. The process was equally successful in all cases.

Development of training materials and their use in a tested training program enhance positive behavior modification and increase the motivation to achieve in patients and staff.

Implications for Action

A plan which includes clearly-stated goals relevant to all of the patient's needs and which specifies deadlines can force the mental health worker to deal with the full range of each patient's needs. A common problem has been that crises or troublesome behavior can command so much of the mental health worker's time and energy that there is no time left to develop the patient's strengths or deal with problems which do not create crisis.

Clearly stated objectives are useful in mobilizing help from community agencies and volunteers. Volunteers are more comfortable and mental health workers are more willing to use volunteers when their involvement is both clarified and limited.

Goal planning procedures make possible a description of patient needs and the resources required to meet those needs. This information is very useful to administrators in deciding what kinds of programs need to be developed in a community. Such information also provides objective, comparative data for program budgeting.

A major implication of goal planning is the potential for upgrading staff status and self-image. The clarity of goals forces increased communication among staff members and between staff and patient and makes achievements and improvements much more visible.

By using behavioral language and spelling out staff responsibilities,

new staff can easily understand what is to be done with patients, and patients can more easily understand their role in treatment. Because untrained persons can easily understand their responsibility, lower echelon personnel may be utilized in working with the mentally ill.

Simple, concrete terms permit workers in several fields to comprehend aims and purposes. This encourages interdisciplinary cooperation. With attention focused on patient's abilities and accomplishments, there is a greater ease in applying techniques from related disciplines.

The individual program mandated by the Rehabilitation Act of 1973 directs its focus fully on the client and vocational rehabilitation. By extending the conscious, positive, and client-oriented attitudes of the mandated program into the treatment center, goal planning provides a means of changing this emphasis to action.

The validity of the goal planning approach is not limited to the mentally ill. Its principles may be applied in the rehabilitation of the mentally retarded, residents of correctional institutions, and to other disabilities. Parallel material for the mentally retarded and residents of correctional institutions have also been developed by the project.

Miss Moriarty is a social science analyst with the Division of Research Utilization, SRS. This article has been compiled primarily from reports supplied by the project director of 15-55122. The mental health training materials mentioned are available from Mental Health Materials Center, Inc., 419 Park Avenue South, New York, New York 10016. Requests for more information on the project should be directed to Dr. Peter Houts, Department of Behavioral Science, The Pennsylvania State University College of Medicine, The Milton S. Hershey Medical Center, Hershey, Pa. 17033.

Publications and Films

The Editors of the SOCIAL AND REHABILITATION RECORD regularly receive notification of the release of new publications and films of interest to readers.

Each issue of the RECORD will carry a selected list of these publications and films with brief discriptions of their contents.

Please address all inquiries and requests to the addresses given in this listing.

Coordinating Human Services. J. Kenneth Benson, Joseph T. Kince, Charles A. Thompson, and David L. Allen. Research Series No. 6, Regional Rehabilitation Research Institute, University of Missouri-Columbia, Columbia, Mo. 65201. 151 pages. $3.

Subtitled, "A Sociological Study of an Interorganizational Network," this monograph sets forth both theoretical and empirical data on the way public agencies do—or do not—join in providing essential public services to persons in need. The study is drawn from surveys made of a nine-county political-economic network involving VR, Welfare, Employment Service, and OEO. Among the conclusions: "The data reveal considerable tension and conflict among the agencies, especially in relationships involving the Community Action Program."

Conducting the People's Business. William G. Hills, Voyle C. Scurlock, Harold D. Viaille, and James A. West, editors. University of Oklahoma Press, 1005 Asp Ave., Norman, Okla. 73069. 491 pages. $19.95 (cloth), $7.50 (paper).

Part textbook, part manual, this new volume gathers together 62 essays or aricles from a wide variety of sources, arranges them in a loose but understandable format, and confronts the new manager or middle manager with basic, useful information for . administering human services programs. The need for such a text appears clear enough: we are told that employment in State and local government has more than doubled over the past two decades, without much noticeable improvement in the quality of the new administrative manpower, a problem since the days of Hammurabi.

The editors of this book were aided by an SRS grant. The University's Press has high hopes for this volume; the last page informs us that the paper used "has an effective life of at least three hundred years."

The Neglected Older American. John G. Cull and Richard E. Hardy. Charles C Thomas, 310-327 E. Lawrence Ave., Springfield, Ill., 62703. 263 pages. $11.95.

The authors and 13 colleagues attempt to lay out many of the needs and problems of today's older American: illness, poverty, unemployment, and disability, to name a few. Chapters on transportation problems of the elderly, religious needs, preretirement counseling, and nursing home care cover still other aspects of life for "a generation whose day did not arrive."

Introduction to Health Planning. David F. Bergwall, Philip N. Reeves, Nina B. Woodside. Information Resources Press, 2100 M St., NW, Washington, D.C. 20037. 221 pages. $15.

This textbook evolved from several semesters of lecturing and writing for a graduate course in Health Project Planning given by the authors at The George Washington University. The approach is interdisciplinary, with data culled from a broad social, medical, political, and economic literature. The approach to "medical marketing" and the chapter on Cost-Benefit Analysis give a useful walk-through of terms and problems. A last-minute prefatory note alerts the reader to post-publication developments, such as the reorganization of the Health activities in HEW and the legislative proposals for national health insurance entering the congressional hopper.

When Mother is a Prefix. Nelson Henry. Behavioral Publications, 2852 Broadway, Morningside Heights, New York, N.Y. 10025. 129 pages. $7.95.

Having worked as a counselor in the field of youth correction, the author has been directly exposed to what he views as society's relative neglect and abandonment of young boys "caged" in detention homes and youth centers. The book's focus, however, is directed away from condemnation and more toward reform. New directions in counseling technique are illustrated by a specific "relations method": The author suggests this practical approach to counselor-group and counselor-individual communication as a further way to effectively help misguided youth to "nurture the priceless habit of future orientation."

Films

How Could I Not Be Among You. Color. 28 min. The Eccentric Circle, Cinema Workshop Ltd., P.O. Box 1418, Evanston, Ill. Sale, $350. Rental, $35.

The title of this film captures a deceptively simple aspect of Ted Rosenthal's "emotional and philosophical" perspective on life and death. Rosenthal, a 31-year-old poet, suffered from acute leukemia and was given very little chance to live. The prognosis changed, however, as his condition was arrested. Having found himself so close to death, the young man learned to face it: he now had to return from that realm of the inevitable and accept the ironic gift of life which death had brought him.

Rosenthal's contemplation and questioning is presented in this film through discussions and through his poetry. Expressing both man's reaction to death and the trauma of his reawakening, this film may help doctors, nurses, clergymen, and other professionals to better understand the human conflict which death arouses.

The Promise of Play. 16 mm. Color. 22 min. Bradley Wright Films, 309 N. Duane Ave., San Gabriel, Calif. 91775.

Children everywhere!—playing, exercising, and competing—all in the spirit of fun and growth. This light, instructive documentary film portrays these children who are orthopedically handicapped as they enjoy progressively more involved and more competitive physical activities.

Discussed throughout the film is the value of a physical education program in "increasing a handicapped child's contact with the world and in increasing meaningful competition within a peer group." This positive outlook is reflected in the progress of individual children and in their interaction with other children outside the program.

BY NOW, JOHNNY HAS LOST THE GUITAR.

A few more months and he won't even hear the bass.

If your child has a hearing problem, there may be a solution through Medicaid. The Medicaid Program treats anemia, TB, and sickle cell disease. It helps prevent polio, whooping cough, and measles. Find out if your family is eligible. Contact your local Social Service or Welfare Office today.

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Career Opportunities

DATA CONTROL LIBRARIAN I. Two years experience as a Data Control Clerk I; or graduation from HS, or equivalent, and at least 4 yrs. general office experience, one of which shall have been in computer operations or data control or the maintenance of a data media library. Courses in computer operation or programming may be substituted for a maximum of 6 months experience. $112.00-134.40/wk. Write: Maine State Department of Personnel, Augusta, Me. 04330.

DATA CONTROL LIBRARIAN II. Two years as a Data Control Librarian I; or graduation from HS, or equivalent, and at least 6 yrs. of general office experience, 3 of which must have been in computer operations or data control or the maintenance of a data media library. Courses in computer operations or programming may be substituted for a maximum of 1 year experience. $134.40-161.60/wk. Write: Maine State Department of Personnel, Augusta, Me. 04330.

DATA CONTROL SPECIALIST. Two yrs. as a Data Control Clerk II; or graduation from HS, or equivalent, and at least 6 yrs. of general office experience, 3 of which must have been in computer operations or data control. Courses in computer operations or programming may be substituted for a maximum of 1 year of experience. $134.40-161.60/wk. Write: Maine State Department of Personnel, Augusta, Me. 04330.

ACCOUNTANT III–AUDITOR III. Bachelor's degree, including 18 semester hr. credits in accounting subjects. (Submit transcript with application.) OR, completion of 24 semester hr. credits of accounting in an accredited college. Four yrs. of experience in responsible phases of accounting or auditing operations. A N.J. driver's license may be required. $10,022-12,884. Write: Department of Civil Service, Front and Montgomery Streets, Trenton, N.J. 08625.

HEAD NURSE. Must be a licensed N.J. professional nurse or must have a letter of permission to work from the State Board of Nursing located at 1100 Raymond Blvd., Newark, N.J. 07102. One year of experience as a professional nurse in a hospital or other institution or clinic. $9,090-12,275. Write: Department of Civil Service, Front and Montgomery Streets, Trenton, N.J. 08625.

DIRECTOR, MENTAL RETARDATION FACILITY. Master's degree in the human services area. Minimum of 4 yrs. of responsible experience in mental retardation or direct human services work, including experience in an administrative and supervisory capacity, OR an equivalent combination of related civilian or military training and/or experience in an administrative/supervisory capacity. $262.10-318.40/wk. Write: Maine State Department of Personnel, Augusta Me. 04330.

NURSING CONSULTANT. Degree in nursing and at least 3 yrs. experience in hospital or public health nursing, including supervisory or administrative duties. $10,751-13,312. Write: State of Alabama, Personnel Dept., Montgomery Ala. 36104.

MEDICAL TECHNOLOGIST II. HS graduate supplemented by successful completion of training as clinical laboratory technician in a school approved by the Council of Medical Education and Hospitals of the American Medical Association, plus 5 yrs. progressively responsible experience in medical technology and lab work, including responsible supervisory experience. $9,672-11,856. Write: State of Alabama, Personnel Dept., Montgomery, Ala. 36104.

Mail your agency's classified listings to Editor, SOCIAL AND REHABILITATION RECORD, DHEW-SRS, Washington, D.C. 20201. Applicants should apply directly to the hiring agency, NOT this magazine. No "situation wanted" or nongovernmental listings accepted. There is no charge or fee of any kind for this service.

ASSISTANCE PAYMENTS SPECIALIST. Associate degree in business administration, accounting, mathematics, bookkeeping, social science, or closely related field and 1 yr. of experience in bookkeeping, counseling, clerical or public contact or closely related field; or HS graduate of GED certificate and 3 yrs. experience of the type specified above; or an equivalent combination of training and experience. $6,656-8,940. Write: State Personnel Office, Townsend Building, Dover, Del. 19901.

SOCIAL WORKER II (PSYCHIATRIC). A bachelor's degree. One year of professional social work experience attained subsequent to the degree. Salary: $9,523-$11,688. Write: N.J. Dept. of Civil Service, Arnold Constable Bldg., Front & Montgomery Streets, Trenton, N.J. 08625.

INSTRUCTOR for RECREATIONAL SUPERVISION TECHNOLOGY. Requires a bachelor's degree with a minimum of 3 yrs. recent and successful experience in the recreational field. Teaching experience desirable. In lieu of a degree, extensive experience or exceptional educational qualifications will be accepted subject to approval of Texas Education Agency. Write: E. R. Billings, Gen. Mgr. for Instruction, Tex. State Technical Institute, Waco, Tex. 76705.

REHABILITATION CONSULTANT. Two yrs. of experience dealing with the handicapped or in the field of vocational rehabilitation or related program of social services. Master's degree in the field of education, business or personnel management, or the social or behavioral sciences or equivalent combination of related military or civilian training and/or experience. $195.70–237.70 per week. Write: Maine State Department of Personnel, Augusta, Me. 04330.

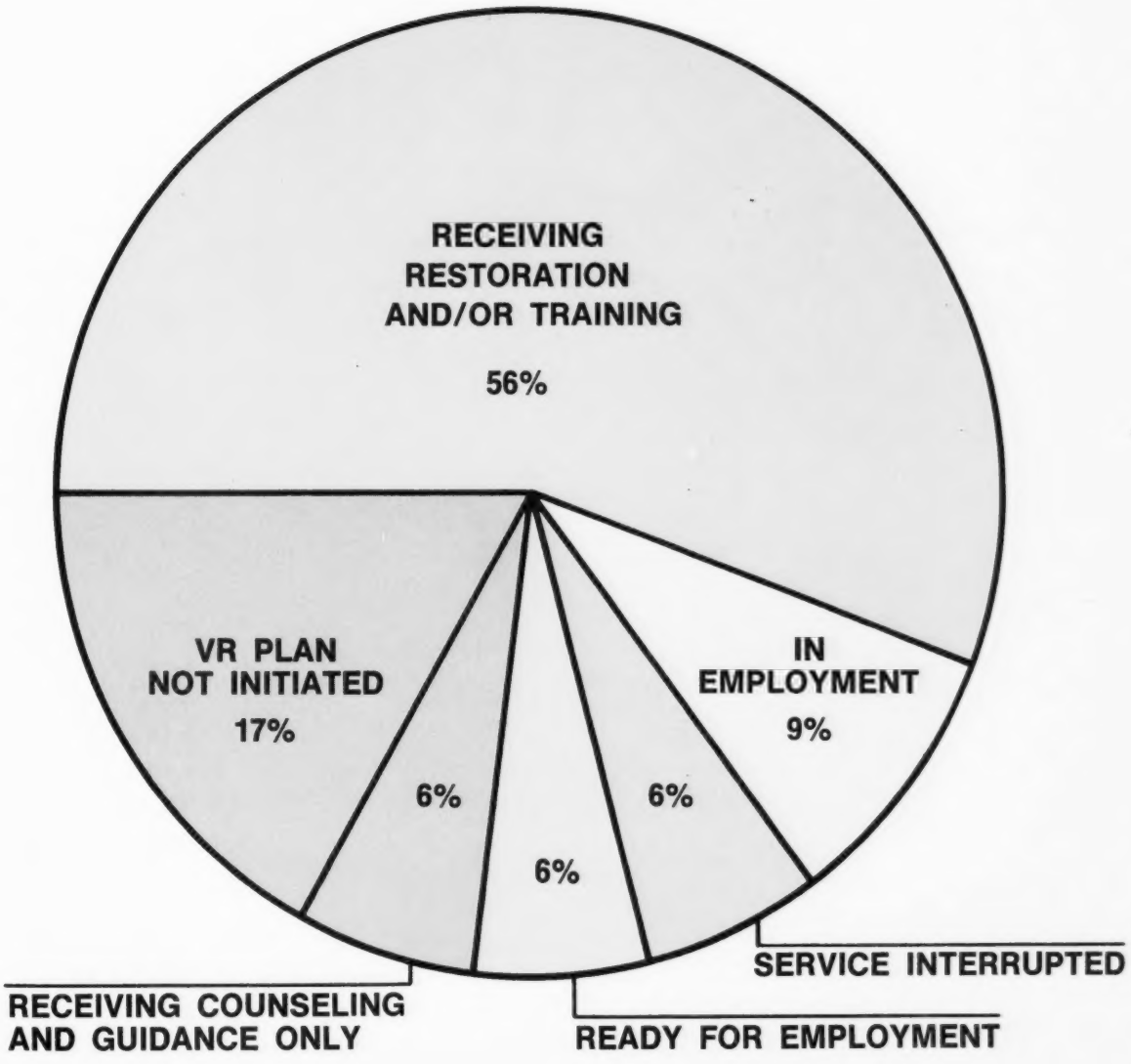
INDUSTRIAL HYGIENIST. Bachelor's degree in a physical or natural science and 1 yr. of experience in applying scientific theories and principles to a field of engineering, a physical or natural science. $10,420–14,616 per year. Write: State Personnel Office, Townsend Building, Dover, Del. 19901.

FIELD REPRESENTATIVE–BUREAU OF AGING. Bachelor's degree or associate degree in public administration, a social or behavioral science, public health, or closely related field and 2 yrs. of experience in gerontology, adult education, community organization, human relations, public health, or closely related field. $7,724–10,937. Write: State Personnel Office, 1228 N. Scott Street, Wilmington, Del. 19806.

REHABILITATIVE SERVICES DIRECTOR. Possession of a Ph.D. degree in a social or behavioral science and 2 yrs. of administrative experience in rehabilitative services with emphasis on correctional institutions of closely related work, or an equivalent combination of training and experience. $12,726–17,766 per year. Location of Work: Ferris School for Boys. Write: State Personnel Office, 1228 N. Scott Street, Wilmington, Del. 19806.

Distribution of Active Caseload Remaining In State Vocational Rehabilitation Agencies June 30, 1973

In fiscal year 1973, State vocational rehabilitation agencies served an active caseload of 1,176,445 persons. A record 360,726 of them were rehabilitated (31 percent), while 11 percent, or 125,991, were not rehabilitated. Those cases remaining on hand as of June 30, 1973 represented 58 percent of the whole (689,728 disabled people). The chart below shows the distribution of these people in the system:



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